THE TAMILNADU
Dr. M.G.R. MEDICAL UNIVERSITY
MADURAI MEDICAL COLLEGE
MADURAI

PSYCHOLOGICAL CASE HISTORY RECORD

DIPLOMA IN PSYCHOLOGICAL MEDICINE

2011 - 2012

THE TAMILNADU
Dr. M.G.R. MEDICAL UNIVERSITY
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MADURAI

CERTIFICATE

This is to certify that this is the bonafide record of Case history study done by Dr. P. HEMALATHA of Diploma in Psychological Medicine II Year, during the year 2011-2012.

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ACKNOWLEDGEMENT

I am deeply indebted to Professor and Head of the Department, Dr.C.P.Rabindranath, M.D.,D.P.M, Department of Psychiatry, Madurai Medical College, Madurai, for the valuable guidance and encouragement he rendered throughout this Case Study.

I am very grateful to Dr.V.Ramanujam, M.D.,D.P.M., Professor, Department of Psychiatry for his valuable support and guidance for the study.

I am very thankful to Dr.T.Kumanan, M.D.,D.P.M., Professor, Department of Psychiatry for his valuable support.

My sincere thanks to the Dean, Madurai Medical College and Government Rajaji Hospital, Madurai for consenting to carry this in the hospital.

I express my profound thanks to Dr.S.Ananda Krishna Kumar, M.D.,D.P.M., Dr. S.John Xavier Sugadev, M.D., Dr M.Karthikeyan, M.D., Dr.G.Amutha, M.D., Assistant Professors, Department of Psychiatry, Madurai Medical College for their support and guidance

I express my gratitude to Assistant Professor cum Clinical Psychologist Mr. N. Suresh Kumar, M.A., M.Phil., whose valuable guidance was indispensable for this study.

And my heartfelt gratitude goes to all my colleagues and staff members of this department for their constant encouragement and support.

I gratefully acknowledge the subjects who co-operated to submit themselves for this study.

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A CASE OF MANIA

Patient: Mr. Madurai Veeran

33 Yrs. Male

Driver

S/O Santhanam

Chinnavirali,

Virudhunagar.

Informant:

Wife, Mrs.Pechiyammal 30 Yrs.

Reliable, consistent and Adequate

REASONS FOR CONSULTATION:

Sleep disturbances	2 ½ months duration
Excessive boastful talk	Insidious onset
Abusive and assaultive behaviour	Continuous/progressive illness
Pacing up and down	III Episode
Possessed by God	I psychiatric episode
Singing songs / dancing	I psychiatric consultation
Excessive spending	
Hyper religiosity	
Frequently taking bath/changing dresses	

HISTORY OF PRESENT ILLNESS:

The patient was found to be normal 2 ½ months back. He was working as a driver. He was indulged in election work. During that time, he return back to home at mid night and worked day and night for the election. He started complaining of body pain and abdominal pain. Following that he started developing sleep disturbances 2 ½ months back. Before the onset of this illness, he had the habit of going to the bed at about 10 P.M. and woke up at 6 A.M. He fell asleep immediately after going to the bed. There was no interruption during sleep. But for the past 2 ½ months he went to bed as usual but fell asleep only around 12.00 and got up at 1.30 A.M. and then would be sitting on the bed/rolling over the bed and looking at the roof. He disturbed others early in the morning and shouted at them. He is pacing up and down during day time and not sits in one place. He voluntarily calls the persons who crosses the street and started to talk excessively and boastfully. He talks in loud voice with new persons as if he knows them previously. He did not go for work and if somebody insisted that he become irritated and abusing them and some times assaulting them. He does not take care of his wife and children. He told that he was possessed by God Pandisamy and started giving blessings to people throughout the day. At times he was singing songs with dancing movements. He was hyper religious and applied kumkum and holyash on the forehead. He collected Lord Siva's photographs and praying in his house.

He used to visit temples twice a day. He used to take bath twice daily and frequently change his dresses about ten dresses per day. He avoids wearing old dresses and started using dresses in the trunk box. He spends more money for buying colourful dresses, chapels and watch. For that his wife fights with him. He expressed anger outbursts towards his family members and beaten them also. Due to worsening of symptoms, his wife brought him here.

No history of head injury/ loss of consciousness.

No history of Seizures.

No history of suspiciousness/hearing voices.

PAST HISTORY:

Five years back he was working at Virudhunagar, after his grandmother's death he began to talk irrelevantly and excessively. He frequently ran away from the house to nearby villages without informing his family members. His sleep was disturbed and started to singing songs with dancing movements. He was abusive and assaultive. He did not go for work and days at home. He talks freely with unknown persons. This episode lasts for three months and subside on its own without any treatment.

Two years back he had another episode. This time there was no precipitating factor and started to talk excessively and boastfully. He had sleep disturbances and not going for work for two months. At that time, his appetite was increased and he frequently asks food. He frequently visits temples and said that he was possessed by God. He was kept at Darga for 15 days and he became all right. No medical treatment given. Between the attacks he was quiet normal.

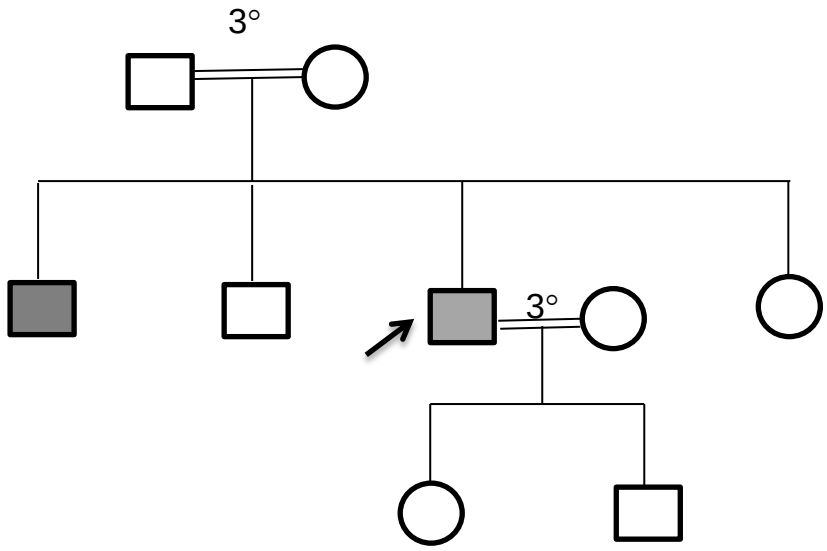
No history of Hypertension/diabetes mellitus.

No history of Suicide attempt.

No history of head injury/loss of consciousness.

No history of seizures.

FAMILY HISTORY:



Patient is the third Sibling of his parents. He is from low socio economical family, from rural area.

Parents :

Father: Mr. Santhanam, 61 Yrs old., Illiterate, working as a farmer, sociable, alive in good Health without major medical or mental illness.

Mother: Mrs. Muniammal, 57 Yrs old, house wife, Illiterate, sociable, alive in good health without any major mental or medical illness.

Parents are blood related third degree consanguineous marriage.

Sibilings :

Mr. Muthu, 38 Yrs old, is the first elder brother of our patient, studied upto third standard. Working as a Farmer, married , having 2 children, he had mental illness (Bipolar affective disorder - Mania), 10 years back. Treated at Govt. Rajaji Hopital, Madurai. Treatment details not known.

Mr. Suruli, 36 Yrs old, is the second elder brother of our patient, studied up to fifth standard, working as a Driver, married, having 3 children and alive in good health without any major medical or mental illness.

Mrs. Shanthi, 30 Yrs old, is the younger sister of our patient, studied upto seventh standard, married and having 2 children and healthy.

Our patient Mr. Madurai Veeran is third in birth order, got married with Mrs. Pechiammal at his 25 yrs of age and has two children. His wife is 30 Yrs old, studied upto fifth standard sociable and Healthy.

Daughter: Baby Kaviya, 6 Yrs. Studying 2nd Std.

Son : Master Santhosh. 2 Yrs. Helathy,

No history of missing persons.

No history of suicidal death.

No history of possession attack.

PERSONAL HISTORY:

Full term normal delivery. Delivered at home, cried immediately after birth, breast feeding for three years. No history of birth asphyxia and mother was normal at the time of delivery.

Early development:

The early developments like head control rolling on the bed, sitting, standing and walking etc., was normal as other babies.

Childhood period:

He was healthy during childhood. No history of thumb sucking / temper tantrum. He played well with other children. At the age of 5 Yrs he joined school and studied up to 8 Std. No history of truancy. No history of emotional / behavioural problem during childhood. His school performance was good. During adolescence, he liked to play Kabadi.

Occupational history:

He was working as a driver and married 8 years back and 3° consanguineous marriage and having 2 children. His sexual life is satisfactory.

Substance abuse history:

History of alcohol intake - 3 years. Once in a month 180 ml.

History of smoking - three years 5 cigarettes per day.

No history of any other substance abuse.

PRE-MORBID PERSONALITY:

Social relationship:

He is very sociable, moves freely with the family members, friends and with relatives and independent. He is very much attached with the family members. He is very much interested in politics.

He is religious and going to temples once in a week. He is always cheerful. He is very rigid. If he decides to do any work, he will do that work orderly, perfectly and methodically. He is very responsible at work.

Character:

He is very sensitive to criticism. He does not suspect others and not jealous of others. He becomes irritated if any body does not obey his commands. He is out spoken. He adapts to any situation.

His personal hobby is reading story books and watching TV. He likes to eat non vegetarian. He took bath regularly and his personal hygiene is adequate. His total pre morbid personality is extrovert type.

General Examination:

Physical Examination:

Pulse rate - 80 / minute, regular

B.P. - 120/80 mm/Hg

Not anaemic /Not Jaundiced & No clubbing/No Pedal edema

Systemic Examination:

Cardio Vascular System : S_1, S_2 heard, No murmur

Respiratory system : Normal vesicular breath sounds heard

Central Nervous system : No focal neurological deficit

Abdomen : Soft, no organomegaly

Fundus examination : Normal

Thyroid : Normal

MENTAL STATUS EXAMINATION:

General Appearance:

Patient is conscious, in touch with surroundings.

Well dressed, tidy and grooming adequate.

Gaze contact made and maintained.

Rapport could be established and cooperative.

No tics/mannerisms noticed

Psychomotor activity: Increased

Attention – Easily aroused, ill sustained

Concentration – Easily distracted

Orientation: Time – able to tell time of day

Place - tell the place

Person- identifies his relatives

Memory Immediate – able to repeat 3 object names.

Recent - able to tell what he ate today morning.

Remote - able to tell his wedding day.

Immediate, recent and remote memories are normal.

Talk Relevant, coherent, excessive, spontaneous speech +

Quantum/ tone/rate - Increased

Reaction time - Decreased.

Pressure of speech +

SAMPLE OF TALK:

நான் ரொம்ப பெரிய ஆளு. என்னை யாரும் மிஞ்ச முடியாது. ஏன் கிட்ட நிறைய சக்தி இருக்கு. அந்த சக்திய வச்சு இங்க இருக்கிற எல்லாரையும் என்னால குணப்படுத்த முடியும். எனக்குள்ள சாமி இருக்கு. நான் தான் சிவன். அந்த பவர வெச்சி ஊரக் காப்பத்தப்போறேன். அடிக்கிற காத்த நிறுத்துவேன். உங்களையெல்லாம் காப்பாத்துவேன். என்னைப்போல எல்லாரும் சந்தோசமா இருங்க.

Content – Inflated self esteem

Delusion of grandiosity,

Thought – Form and stream - Normal

Perception - No perceptual disturbances.

Mood: Subective: ரொம்ப சந்தோசமா இருக்கு

Objective: Elated, reactive, congruent and no emotional lability.

General information and intelligence: Adequate for his knowledge.

Abstract Thinking: Proverb Test: Impaired.

He has given two proverbs. He is not able to tell the abstract meaning, but able to tell the concrete meaning of the proverb.

Judgment: Impaired

Insight: Absent

PSYCHOMETRY:

Patient was administered.

1. RORSCHACH INK BLOT TEST
2. THEMATIC APPERCEPTION TEST
3. SENTENCE COMPLETION TEST
4. EYESENCK'S PERSONALITY INVENTORY

RATIONALE:

Rorschach's test was admitted to find out the psychodynamics and psychopathology of the individual.

TAT was administered to find out interpersonal and intrapersonal problems.

EPI was found out the personality of the individual.

PSYCHOLOGICAL REPORT:

In Rorschach his responses shows quick mentation and above average productivity. He had given at an average of 4 responses to a card. There was greater colour responses and details, whole responses. There are CF responses are seen. A form level shows impaired reality testing.

The Sentence completion test and Thematic apperception test responses reveal his excessive preoccupation with religion and related activities. He also expresses over confidence in overcoming his life problems and is optimistic of the future.

In Eyesenck's personality inventory, he is found to be an extrovert.

Diagnostically, the evidence of quick reaction time, average productivity, over confidence and optimism, indicate a mood disorder – Mania.

YOUNG MANIA RATING SCALE:

Findings - Total Score = 34

DIAGNOSTIC FORMULATION:

Madurai Veeran, 33 Yrs. Married Male patient brought with complaints of Sleep disturbances, excessive boastful talk, abusive/assaultive behaviour, pacing up and down, Over familiarity, possessed by God, singing songs and dancing, excessive spending, hyper religiosity, frequently taking bath and changing dresses for the past 2 ½ months, insidious onset, III episode of illness with first psychiatric consultation, with past history of 2 episodes of mania, with family history of mental illness, with personal history of alcohol intake and smoking, Pre Morbid Personality of extravert on Mental Status Examination revealing attention aroused but ill sustained, increased psychomotor activity, excessive boastful talk with decreased reaction time, with pressure of speech, with inflated self esteem with delusion of grandiosity with elated mood with impaired judgement and abstract thinking with absent insight with no features of organicity, with psychometric findings of quick reaction

time, average productivity, over confidence and optimism, indicate mood disorder – Mania without psychotic features.

IMPRESSION:

MANIA WITHOUT PSYCHOTIC FEATURES ICD 10 No. – F.30.1

Management:

Patient was treated as inpatient at Government Rajaji Hospital, Madurai, for 25 days. He was investigated, complete hemogram (TC,DC,ESR,HB), Liver function test and Renal function test were done. All are with in normal limits. He was treated with Tab. Sodium valproate 200 mg two tds.

Tab. Haloperidol 1.5 mg one tds.

Tab. Diazepam 5 mg two HS

Tab. B complex one bd

Six Electroconvulsive therapies was given – three ECTs per week (alternate days).

His family members were educated about the nature of the illness and premonitory symptoms and relapses. At the time of discharge his Young mania rating scale was 19. Patient was discharged after 25 days and advised to continue Tab. Sodium Valproate 200 mg. two tds. and Tab. Risperidone 2 mg. one bd. and Tab. B-Complex one bd. Patient was advised to attend psychiatry Out-Patient Department for regular follow up once in 14 days.

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A CASE OF DEPRESSION

Patient: Mrs. Shanthi

35 Yrs. Femle

House wife

W/O Sankar

Aviyoor, Kariyapatti,

Madurai.

Informant:

Husband, Mr.Sankar, 39 Yrs.

Reliable, consistent and Adequate

REASONS FOR CONSULTATION:

Sleep disturbances	1 ½ months duration
Loss of interest in work	Insidious onset
Crying Spells	Continuous/progressive illness
Easy fatigability	I psychiatric episode
Lamenting	I psychiatric consultation
Decreased appetite	
Suicidal wishes.	

HISTORY OF PRESENT ILLNESS:

The patient apparently normal 1 ½ months back. She is staying with her husband and children. She did her household work regularly. She

started developing sleep disturbances 1½ months back. Before the onset of this illness, she had the habit of going to the bed at about 10.30 P.M. and woke up at 6 A.M. There was no interruption during sleep. But for the past 1 ½ months she went to bed as usual but fell asleep only around 12.00 mid-night and got up at 4.30 A.M. and then would be sitting on the bed/rolling over the bed. She had difficulty in initiation and continuation of sleep. She does not feel fresh on getting up. She feels very low mood in the morning and she is not interested in preparing food. She felt somewhat better in the evening.

She started to lamenting about her sleep disturbances and expressed loss of interest in her household works. Previously she used to watch T.V serials regularly and very much interested in hearing songs in radio. During the period of illness she is not interested in watching T.V and hearing songs in radio. She used to talk with her neighbours during free times. But during the period of illness she is not interested in talking with others.

At times she cried and expressed fatigability even for simple works. She is not taking care of her children and husband. Her food intake was decreased and she was persuaded to take food by her husband. She has lost weight. She frequently expressed worthlessness and suicidal wishes. 3 days back she was admitted for fatigability at Govt. Rajaji Hospital, Madurai. She was referred to Psychiatry Out Patient department from medical ward.

No history of head injury / loss of consciousness.

No history of cold intolerance.

No history of constipation.

No history of suspiciousness.

No history of hearing voice.

No history of talking or laughing to herself.

PAST HISTORY:

No history of mental illness previously

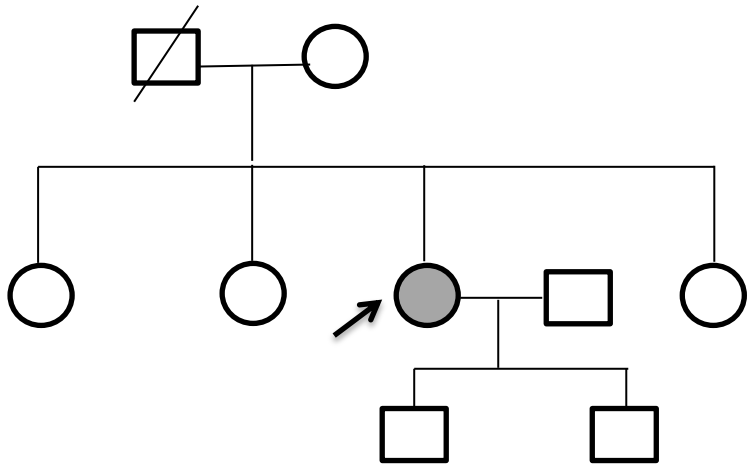
No history of head injury/loss of consciousness.

No history of Hypertension

No history of Diabetes mellitus

No history of seizures.

FAMILY HISTORY:



Patient is the third sibling of her parents. She is from low socio-economical family, from rural area.

Parents:

Father: Mr. Muthu, died of physical illness 5 years back.

Mother: Mrs.Pushpam, 70 Yrs old, housewife, staying with her first daughter.

No history of major medical / mental illness.

Parents are not blood related.

Siblings:

Mrs. Santhanalakshmi, 43Yrs. old, first elder sister of our patient, studied up to fifth standard, married, having 2 children and healthy.

Mrs. Indhrani, 40 Yrs.old, second elder sister, no history of major medical or mental illness, married and having 1 child.

Mrs. Kalaiselvi 32 Yrs. old, younger sister, studied up to eighth standard, healthy, married and having 2 children.

Our patient Shanthi is the third one in the birth order, got married to Mr.Sankar at her 22 years of age, has two male children.

Patient's husband, Mr.Sankar, 39 Yrs. old, working as mechanic, is an alcoholic, not adjustable person. He is not affectionate to his wife and children.

Children: Master Prakash, 10 Yrs. healthy, studying 5th Std.

Master Kavin, 9 Yrs, healthy, studying 4th Std.

No history of mental illness.

No history of missing persons.

No history of suicidal death.

No history of possession attack.

PERSONAL HISTORY:

Birth and Developmental History:

Full term normal delivery. Delivered at home, cried immediately after birth. No history of birth asphyxia, Neonatal jaundice and Neonatal seizures. No history of delay in developmental milestones. Breast feeding for two years.

Childhood period:

She was healthy during childhood. No history of thumb sucking / temper tantrum. At the age of 5 she joined school and studied up to 7th Std. Her school performance was good.

Menstural History:

She attained menarche at the age of 13 and regular menstrual cycle. No history of premenstrual symptoms.

Marital History:

She got married 13 years back and having 2 male children. Full term normal delivery. Family planning done 7 years back.

Her sexual life is satisfactory.

Her personal hobby is watching TV.

No history of substance abuse.

PRE-MORBID PERSONALITY:

Social relationship:

She is less sociable. She had very limited number of friends. She does not mingle with her neighbours.

Mood:

She frequently worries over minor issues and starts weeping even for minor grief situation. She is pessimistic. She used to think about past sadful events and feel sad.

Character:

Her moral and religious standards were moderate. She is soft spoken and very sensitive to criticism. She is affectionate towards towards her family members.

Intellectual activities:

She is sincere in her work. She is always busy with her house hold works and taking care of her children. Her total pre-morbid personality is more of an introvert.

General Examination:

Physical Examination:

Pulse rate - 82 / min, regular.

B.P. - 110/80 mm/Hg

Not anaemic / Not Jaundiced & No clubbing /No Pedal edema

Systemic Examination:

Cardio Vascular System : S_1, S_2 heard, No murmur

Respiratory system : Normal vesicular breath sounds heard

Central Nervous system : No focal neurological deficit

Abdomen : Soft, no organomegaly

Fundus examination : Normal

Thyroid : Normal

MENTAL STATUS EXAMINATION:

Patient is conscious, in touch with surroundings.

Dressed neatly and adequately. Rapport established.

Her gaze contact made but not maintained.

She frequently looks down and tries to cry in between interview.

Sits with a stooped posture.

No tics /mannerisms noticed.

Psychomotor activity: Decreased

Attention **:** Arousable and sustained

Concentration **:** Adequate.

Orientation **:** Time – able to tell time of day

Place - able to tell the place

Person - identifies her relatives

Memory: Immediate – registration and recall adequate.

Recent - able to tell what she ate in the yesterday night.

Remote - able to tell her wedding day.

Her immediate, recent and remote memories are adequate.

Talk: Relevant, coherent.

Quantum/ tone/rate decreased

Reaction time increased.

SAMPLE OF TALK:

எனக்கு கவலையா இருக்கு. முன்ன மாதிரி தூங்க முடியல. பசங்களை கூட பாத்துக்க முடியல. சமைக்க முடியல. யார் கூடவும் பேசக் கூட ஆசையா இல்ல. பசங்க வெளையாட்டுச் சத்தங்கேட்டாக்கூட கோபமா வருது. சாப்பாடு புடிக்கல. என்னால யாருக்குமே எந்த உபயோகமும் இல்ல. ஏன்டா இருக்கிறமோனு எண்ணம் வருது. பேசமா செத்துப் போயராலமுனு தோணுது.

Thought – Form and stream normal.

Content – Ideas of hopelessness.

Ideas of worthlessness.

Anhedonia / Suicidal wishes.

Perception - No perceptual abnormality.

Mood: Subjective: ரொம்ப கவலையா இருக்கு

Objective: Depressed, reactive, congruent and full range preserved.

General information and intelligence: Adequate.

Abstract Thinking: Proverb Test

She has given two proverbs.

She is able to tell concrete and abstract meaning of proverb.

Judgment: Her personal and social judgement adequate.

Judgement on test situation – adequate.

Insight - 4/6

PSYCHOMETRY:

Patient was administered with

1) RORSCHACH INK BLOT TEST
2) THEMATIC APPERCEPTION TEST
3) SENTENCE COMPLETION TEST
4) EYESENCK'S PERSONALITY INVENTORY
5) HAMILTON DEPRESSION RATING SCALE
6) MONTGOMERY ASBERG DEPRESSION SCALE

PSYCHOLOGICAL REPORT:

Rorschach test was administered to find out psychodynamics and psychopathology. It reveals that the productivity is normal but the cerebration is slow. The patient has taken an average time of 40 seconds in Rorschach. There is evidence for high aspirations as evidence from high percentage of W responses. Achromatic shading is present revealing depressed mood. There are few anatomical responses. Popular responses are present. The form level rating is average. These indicate that reality is not impaired.

Thematic Apperception Test and Sentence Completion Test indicate depressed mood, pessimism, a negative estimation about self.

Eyesenck's Personality Inventory – She is found to dysthymic.

Hamilton Depression Rating Scale – scoring of 39

Montgomery Asberg Depression Scale – scoring of 26, which indicates moderate depression.

DIAGNOSTIC FORMULATION:

Shanthi, 35 Yrs. married female patient brought with complaints of Sleep disturbances, loss of interest in work, crying spells, lamenting, loss of appetite, fatigability, suicidal wishes for the past 1 ½ months, insidious onset, continuous and progressive illness, first psychiatric consultation, with Pre-morbid personality of an introvert and on Mental status examination revealing decreased psychomotor activity with talk quantum tone and rate decreased, reaction time increased with ideas of hopelessness and worthlessness with anhedonia with suicidal wishes with depressed mood with insight present, no features of organicity and a positive psychometric profile of depression, a clinical diagnosis of moderate depression is made.

IMPRESSION:

MODERATE DEPRESSION – ICD 10– F.32.1

Management:

Patient was admitted at Govt. Rajaji Hospital Madurai, for 21 days. Investigation were done. Blood TC,DC,ESR,HB, Liver function test, Renal function test and thyroid profile were with in normal limits. She was treated with Cap. Fluoxetine 20 mg. 1-0-0 and Tab. Diazepam 5 mg. One HS and Cognitive behavioural therapy given. Her family members were educated about the nature of illness. At the time of discharge her symptoms subsided and her Hamilton Depression Rating Scale Score was 21. She was discharged after 21 days and advised to continue the same drugs. She was advised to attend psychiatry Out Patient Department once in 14 days for regular follow up.

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A CASE OF DELUSIONAL DISORDER

Patient: Mrs. Badrakali

50 Yrs. Female

Widow

M/O Ganesan

Josiyar Compound,

Indira Nagar, Solai Alagupuram, Madurai.

Informant:

Son Mr.Ganesan, 30 Yrs.

Reliable, consistent and Adequate

REASONS FOR CONSULTATION:

Saying insects are present in her scalp and skin	1 Year duration
Spending lots of time searching for these insects	Insidious onset
Keep combing scalp and body throughout the day	Continuous /progressive illness
Itching sensation all over the body	1st Psychiatric
Sleep disturbances	consultation

HISTORY OF PRESENT ILLNESS:

The patient is a widow and stayed in her son's house. She is usually careful regarding the cleanliness of the house and her personal hygiene. One year back she said that insects are present in scalp and skin. She started to combing her hair repeatedly and searching for insects in her hair. Family members thought that she had lice in her hair and joked to her

about it and even encouraged her to search harder and clean herself. After a few weeks they found that her behaviour was slightly out of the ordinary and that she was spending excessive time trying to find these insects. Even when guests are in the house, she used to scratch her head. She was asked not to do, but she continued, saying it is full of insects.

After two months she slowly started feeling crawling sensation of insects under the skin extending from the scalp through her body up to her limbs. She started scratching her skin all over the body with the comb throughout the day.

This aroused suspicion in her son, who questioned her closely. Initially she tried to brush it off. After persistent questioning, she admitted that her skin is full of insects, crawling here and there. And that she is trying to get rid of them.

When family members asked her to show at least one insect, she said that as soon as she catches them, it flies. And that she is yet to see even one insect. Family members tried convincing her that nothing is wrong with her, but she simply did not accept it.

She had intermittent sleep disturbances. She used to initiate sleep with difficulty, she used to get up with in a hour, due to intolerable itching and keeping combing her hair and body throughout the night, she used to get up 3-4 times in the night. Due to continuous itching sensation she could not concentrate in her regular house hold activities.

She was then taken to a nearby general practitioner, who treated her with injection and tablets. He ordered a few investigations (details not known) which turned out to be normal. In spite of that she did not improved. He then referred her to a skin specialist, who also treated her without any improvement.

Because of treatment failures, patient was taken to various temples and other such places for treatment. But they all failed.

Finally she was brought to Skin Department, Government Rajaji Hospital, Madurai. After investigation (which are within normal limits), she was referred to Psychiatry Out Patient Department for evaluation.

No history of loss memory or way finding difficulty.

No history of Suicidal ideas/attempts.

No history of talking to self / laughing to self

No history of suspiciousness/crying spells

No other behaviour abnormalities noticed.

No history of drug intake.

PAST HISTORY:

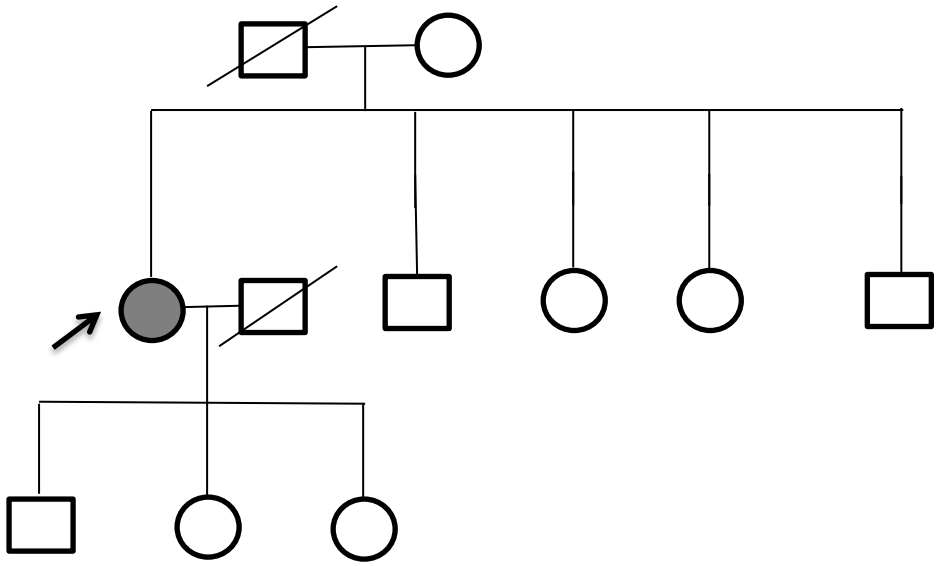
No similar episodes before.

No history of hypertension, diabetes / tuberculosis

No history of head injury/loss of consciousness.

No history of seizures.

FAMILY HISTORY:



Patient is the first daughter of her parents and she belongs to low socio economical family, from rural area.

Parents :

Father : Mr. Marriyappan, died of myocardial infarction 20 yrs back.

Mother : Mrs.Kalyani, 80 Yrs old , Illiterate, sociable. She is housewife.

Alive in good health without any major mental or medical illness.

Parents are not blood related.

Sibilings :

Mr. Murugan, 48 Yrs old, first younger brother of our patient, Illiterate, working as a farmer, healthy, married and having 3 children.

Mrs. Marriyammal, 45 Yrs old, first younger sister of our patient, studied upto fifth standard, married and having 2 children, alive in good Health without any major medical or mental illness.

Mrs. Pandiyammal, 43 Yrs old, second younger sister of our patient, studied upto third standard, Healthy, married and had 2 children.

Mr. Veeran, 40 Yrs old, second younger brother of our patient, history of alcohol dependence present, married and had 3 children.

Patient's husband Mr. Annamalai, died of physical illness 5 years back.

Patient's son Mr. Ganesan 30 Yrs. working at a private company, healthy, married and having 2 children. Patient is stayed with him.

Patient's daughter Mrs.Manimekalai, 28 Years old, studied upto 10th standard, healthy, married and living with her family.

Patient's daughter Mrs.Sindhamani, 25 Years, studied up to 12th standard, healthy, married and living with her family.

No family history of mental illness / epilepsy.

No family history of missing persons.

No family history of suicidal death.

No family history of possession attack.

PERSONAL HISTORY:

Birth and development:

Born of a non consanguineous marriage.

Birth and early development details are not known. Uneducated.

Menstural History:

She attainted menarche at the age of 14 years. Regular cycle. She attained menopause 3 years back.

Marital History:

Married her distant relative and having 3 children. Her husband died 5 years back due to physical illness. Now she is staying in her son's home.

No history of betal nut chewing.

PRE-MORBID PERSONALITY:

Social Relationship:

Independent, easily mingle with others, attend all family functions. Maintains good social and interpersonal relationship.

Intellectual activities:

She is very sincere and hard working, busy with her house hold works and taking care of her grand sons.

Mood:

Unstable mood, she is always worrying about her son and daughters. She is very affectionate towards her family members.

Character:

Welcomes work, soft spoken, moral and religious standards are moderate. She is very much concerned about her health, she is energetic, sleep normal, she is not self medicated.

She spends her free time by watching TV and helping her children in what ever way she can. Her frustration tolerance was good.

She was very sensitive to criticism. But she was not stubborn.

Her total premorbid personality is extroverted type.

General Examination:

Physical Examination:

Pulse rate - 84 / min, regular.

B.P. - 120/80 mm/Hg

Not anaemic / Not Jaundiced & No clubbing /No Pedal edema

Systemic Examination:

Cardio Vascular System	:	S_1, S_2 heard, No murmur
Respiratory system	:	Normal vesicular breath sounds heard
Central Nervous system	:	No focal neurological deficit
Abdomen	:	Soft, no organomegaly
Fundus examination	:	Normal
Thyroid	:	Normal

MENTAL STATUS EXAMINATION:

Patient is conscious, in touch with surroundings.

Dressed neatly and adequately.

Gaze contact made and maintained.

Rapport could be established and cooperative.

No tics/mannerism noticed.

Psychomotor activity: Normal

Scratches her head and skin, and keeps trying to catch the insect, which she is unable to show when asked to.

Attention – Arousable and ill sustained

Concentration – Easily distractable.

Orientation: Time – able to tell time of day

Place - tell the place

Person- identifies her relatives

Memory: Immediate – able to repeat 3 object names.

Recent - able to tell what she ate today morning.

Remote - able to tell her past experiences.

Immediate, recent and remote memories are normal.

Talk Relevant, coherent.

Quantum/ tone/rate normal

Reaction time normal.

SAMPLE OF TALK:

‘‘ ஒரு வருசத்துக்கு முன்னால தலை முடியில பூச்சி மாதிரி ஒட்டிக்கிட்டு இருந்தது. கொஞ்ச நாள்ல தலையெல்லா ஊர ஆரம்பிச்சிடுச்சு. அதனால சீப்ப போட்டு சீவிட்டே இருந்தேன். நாள் ஆக ஆக அதிகமாயிடுச்சு. கொஞ்ச நாளைக்கப்புறம் அந்த பூச்சி தலையில இருந்து ஒடம்புக்கு எறங்க ஆரம்பிச்சிடுச்சு. தோலுக்கடியில எல்லாம் ஊர்ர மாதிரி இருக்கு. தலையில் இருந்து கால் வரைக்கும் அரிக்குது. எப்ப பாத்தாலும் சீப்ப போட்டு சீவிக்கிட்டே இருப்பேன். சீவி சீவி தோலெல்லாம் புண்ணாயிடுச்சு. ராத்திரி பகல் எல்லாம் நேரமும் அரிக்கிறதால வேலைவெட்டி எதுவும் பாக்க முடியல. தூக்கம் வரல.’’

Content – Delusion of parasitosis.

Thought – Form and stream – Normal

Perception - Tactile hallucinations +

Mood: Subjective : கஷ்டமாயிருக்கு

Objective : Anxious, reactive, appropriate and congruent.

General information and intelligence: Adequate.

Abstract thinking: Proverb Test: Impaired

Patient has given two proverbs. She is able to tell the concrete meaning but not able to tell the abstract meaning.

Judgment: Test / Personal / Social - Normal

Insight - absent

PSYCHOMETRY:

Patient was administered.

1) RORSCHACH INK BLOT TEST
2) THEMATIC APPERCEPTION TEST
3) SENTENCE COMPLETION TEST
4) EYESENCK'S PERSONALITY INVENTORY

The patient remained co-operative. She showed normal motivation and interest. Most of her responses confine to insects, showing her

preoccupation with her delusion. She also has somatic preoccupations. Popular responses are present and form level is good. The Thematic Apperception Test - stories are descriptive and again show her concern for her illness.

In Eyesenck's personality inventory- she is found to be an extrovert.

The L Score is not significant.

The profile indicates the possibility of Delusional Disorder.

DIAGNOSTIC FORMULATION:

Badrakali, 50 Yrs. old Female patient brought with the complaints of saying insects are present in her scalp and skin, spending lots of time searching for these insects, Itching sensation all over the body, keep combing scalp and body throughout the day, sleep disturbances for the past 1 year, insidious onset, continuous and progressive illness, first psychiatric consultation with no family history of mental illness with Pre-morbid personality of extrovert on Mental Status Examination revealing talk relevant and coherent with delusion of parasitosis with tactile hallucinations with mood anxious and congruent with attention aroused but ill sustained with impaired abstract thinking with absent insight with no features of organicity and psychometric findings indicates possibilities of a delusional disorder.

IMPRESSION:

DELUSIONAL DISORDER – HYPOCHONDRIACAL (SOMATIC) TYPE

Management:

Patient was admitted at Govt. Rajaji Hospital, Madurai and Investigations done. Complete hemogram (TC,DC,ESR,HB), Liver function test and Renal function test are with in normal limits. CT brain normal study. Patient was treated with Tab. Risperidone 2 mg. bd. and Tab. Diazepam 5 mg. 2 HS. for 21 days. Patient has improved. Patient discharged after 21 days and advised to continue Tab. Risperidone 2 mg. bd. and advised to attend psychiatry out patient department for regular follow up. Patient's relatives were educated about the nature of illness.

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A CASE OF OBSESSIVE COMPULSIVE DISORDER

Patient: Mr. Balaji	**Informant:**
17 Yrs. Male	Self & Mother
10th std.	Mrs. Lakshmi 38 Yrs.
S/O Murugan	Reliable, consistent and Adequate
Veera Kaliamman street,	
Jayanthipuram, Madurai.	

REASONS FOR CONSULTATION:

Recurrent intrusive thoughts about contamination and doubts	6 months duration
Repeated checking	Insidious onset
Repeated washing	Continuous/progressive illness
	I Psychiatric episode
	I Psychiatric consultation

HISTORY OF PRESENT ILLNESS:

Patient was apparently normal 6 months back. He is living with his parents. He was appearing IX standard annual examination, when he had a doubt recording question paper. He had 10 questions, he knew the ninth question well. He had a doubt whether to write the first or ninth. He

repeatedly asked to his friend and the school teacher about it. They scolded him for that. From the time onwards, he had recurrent doubts in filling the forms, writing serial numbers etc., for example: If he has to write numbers 1,2,3,4,…he would have a doubt whether to leave space in between or fill continuously. Recording writing his name, he would have a doubt whether the first letter should start with capital followed by small letters or the whole name should be written in capital letters. He also had problem in writing sentences. He would write the sentence and have a doubt if it was correct and then rub it off, and write it again. He would do so for 2 to 3 times. After completing the examination or test papers he would repeatedly check if he has written all the questions, serial numbers correctly, his name, register number about five times before handing over.

He would also repeatedly check whether he has locked his cycle or not. After parking the cycle he would go to class room and come back for 3 to 4 times to check whether the cycle is locked or not. For this activity the teachers scolded him many times.

A few days later, he started taking bath for prolonged period about 2 hours. He would keep wiping with a towel for a long time. When his mother asked him why he was doing so, he would tell that dirt particles were present in his body. He also had fear of contamination with germs. One month back he went to a swimming pool and stayed inside the water for hours. After coming back, he repeatedly washed his hands and legs every 15 minutes, and fearing of contamination and germ infection.

If a dog passes near him he would feel as if it has licked him in his feet and would continuously wash it with water and fearing of contamination. As he spent most of his time for repeated checking and washing, he would not concentrate in his studies and his scholastic performance was deteriorated.

No history of fear of any object or places.

No history of fever / seizures

No history of head injury / loss of consciousness

No history of talking / laughing to himself

PAST HISTORY:

No history of previous mental illness.

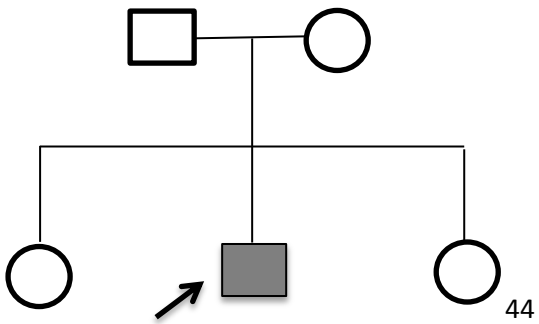
No history of Hypertension/diabetes mellitus.

No history of Suicide attempt.

No history of head injury/loss of consciousness.

No history of seizures.

FAMILY HISTORY:



Born of non consanguineous marriage. He is the second child of his parents, from low socio economical family and from rural background.

Parents:

Father:

Mr.Murugan, 43 years old, studied up to 10th standard. Working as tea master, alive in good health without major medical / mental illness.

Mother:

Mrs.Lakshmi, 38 years old, studied up to 8th standard, house wife, healthy.

Siblings:

Selvi.Rani 19 years old, elder sister of our patient, studying B.Sc., Maths first year and healthy.

Our patient is the second child of his parents.

Master Vinoth, 13 years old, younger brother of our patient, studying 8th standard and healthy.

No family history of mental illness.

No history of missing persons.

No history of suicidal death.

No history of possession attack.

PERSONAL HISTORY:

Birth and development:

Full term normal delivery delivered in hospital, cried immediately after birth, no history of birth asphyxia, neonatal jaundice/seizures. No history of delayed milestones.

Childhood period:

He was healthy during childhood. No history of thumb sucking / temper tantrum. He started schooling at the age of 6 years, average in his studies, discontinued his 10^{th} standard, because of the illness. No history of truancy. He is very much interested in extra curricular activities like drama, playing games and swimming.

PRE-MORBID TRAIT:

He is less sociable and prefers loneliness. From the early childhood he used to be very neat always and keeps his things like dress and books in a neat order. Does not like others to handle his matters and get irritated if any changes in the order. He is responsible, has high standard of moral and discipline, worries for trivial matters and pessimistic.

General Examination:

Physical Examination:

Pulse rate - 80 / min, regular.

B.P. - 110/80 mm/Hg

Not anaemic / Not Jaundiced & No clubbing /No Pedal edema

His both palms and inter digital clefts are very pale and white due to repeated washing.

Systemic Examination:

Cardio Vascular System : S_1, S_2 heard, No murmur

Respiratory system : Normal vesicular breath sounds heard

Central Nervous system : No focal neurological deficit

Abdomen : Soft, no organomegaly

Fundus examination : Normal

Thyroid : Normal

MENTAL STATUS EXAMINATION:

Patient is conscious, in touch with surroundings.

Neatly dressed and adequately built.

Gaze contact made and maintained.

Rapport could be established and cooperative.

No tics/mannerism noticed.

Psychomotor activity: Normal

Attention and Concentration – Arousable and sustained

Orientation Time – able to tell time of the day

Place - tell the place

Person- identifies the doctor

Memory: **Immediate** – DFW-6 digits, DBW-4 digits.

Recent - able to tell what he ate yesterday morning.

Remote - able to tell his school experiences.

Immediate, recent and remote memories are normal.

Talk Relevant, coherent.

Quantum/ tone/rate normal

Reaction time normal.

SAMPLE OF TALK:

மனசுல திரும்பத் திரும்ப எண்ணங்கள் வருது. யாராவது என்னைத் தொட்டால் அழுக்கு ஒட்டிக்கொள்ளுமோனு, ரோட்டில நடந்து போனா அழுக்காயிடுமானு தோணுது. அடிக்கடி அந்த நெனப்பு வருது. என் நெனப்புதான் ,

நானாத்தா நெனைக்கிறேன். திரும்பத் திரும்ப அந்த நெனப்பு வரது கஷ்டமா இருக்கு. தடுக்கனும்னு பாக்கறேன் , முடியல. அதனால அடிக்கடி கை , கால் கழுவுறேன். நெறய தடைவ குளிக்கிறேன். ரொம்ப நேரம் சோப்பு போட்டு தேய்ச்சு குளிச்சாளும், அழுக்கு போன திருப்தி வரல. ஏதாச்சும் டெஸ்ட் எழுதுனா எந்த நெம்பர் மொதல்ல போடனும், பேர் கரெக்டா எழுதினேனா? நெம்பர் கரெக்ட்டா எழுதினேனான்னு திரும்ப திரும்ப டவட் வருது. அஞ்சாறு தடவை செக் பண்ணுவேன். அப்படி திரும்பப திரும்ப செய்யறது கஷ்டமா இருக்குது.

ஸ்கூல்ல சைக்கிளை நிறுத்தி பூட்டினப்புறம் கிளாஸ்க்கு போன பிறகும், பூட்டினமா? இல்லையானு திரும்பத்திரும்ப டவுட் வருது. மூனு நாலு தடவை வந்து செக் பண்ணிட்டுப் போவேன். அப்பதான் கொஞ்சம் திருப்தியா இருக்கும். இதனால டீச்சர் திட்டராங்க. இதனால சரியாப் படிக்க முடியல

Thought:

Content – Obsessional thoughts

Recurrent intrusive thoughts about contaminations and doubts

He recognized that it was his won thoughts but he is not able to control and it produces distress.

- Compulsive acts

Repeated checking and washing.

Perception - No hallucinations.

Mood: **Subective:** கஷ்டமா இருக்கு

Objective: Depressed,Congruent and reactive.

General information and intelligence: Adequate.

Abstract Thinking: Proverb Test:

Able to tell the abstract meaning and concrete meaning of the proverb.

Judgment: Personal/Social/Test situation – Normal.

Insight - present

PSYCHOMETRY:

Patient was administered.

1) Rorschach Psycho diagnostics.
2) TAT (thematic apperception test)
3) SCT (sentence completion test)
4) EPI (eyesenk's personality inventory)
5) Yale Brown obsessional rating scale.

The findings reveal that the individual has normal mentation and average productivity. There is evidence for high W responses showing high aspirations. There were excessive FM responses. Popular responses are present. The form level too reveal that the reality testing is not much impaired. The thematic apperception and sentence completion test

responses reveal a sense of guilt and suicidal ideas. He is undecided about the future.

In Eysenck's personality he is found to be an introverted, neurotic a dysthymic. The 'L' score is not significant. Diagnostically the evidence for 'd' responses and dysthymic personality dimension would favour a diagnosis of obsessive compulsive neurosis.

Y-Bocs – Obsessional rating scale – 12.

Compulsion rating scale – 8

Total Score- 20 (Moderate)

DIAGNOSTIC FORMULATION:

17 years old Balaji came with the history of repetitive intrusive thoughts about contamination and doubts, repeated checking and repeated washing for the past 6 months insidious onset continuous and progressive illness, first psychiatric consultation with no positive family history of any mental illness, with premorbid trait of introvert on mental status examination revealing obsessional thoughts about contamination and doubts, repetitive compulsive acts of washing and checking with depressed mood with preserved judgement and insight suggesting the diagnosis of obsessive compulsive disorder with the psychometry reports also suggesting the same diagnosis.

IMPRESSION:

OBSESSIVE COMPULSIVE DISORDER ICD 10 No.42.2

(mixed obsessional thoughts and compulsive acts)

Management:

Patient and his family members prefers out patient treatment, he was treated with Cap. Fluoxetine 20 mg. 1-0-0 and Tab. Diazepam 5 mg. HS. Behavioural therapy – thought stopping given. Patient was advised to attend psychiatry out patient department, Govt.Rajaji Hospital, Madurai. once in 14 days for regular follow up. His family members were educated about the nature of the illness.

*****

A CASE OF PARANOID SCHIZOPHRENIA

Patient: Mr. Subramani

25 Yrs. Male

Driver

S/O Kulandaivelu

Vagadakattupatti,

Kannarpatti, Dindugal Dt.

Informant:

Wife Malliga 22 Yrs.

Reliable, consistent and Adequate

REASONS FOR CONSULTATION:

Sleep disturbances

Withdrawn

Suspiciousness

Talking to self

Laughing to self

Hearing voices

Abusive and assaultive behaviour

Not going for work

Decreased food intake

Poor personal care

9 month duration

Insidious onset

Continuous/progressive illness

I Psychiatric episode

I Psychiatric consultation

HISTORY OF PRESENT ILLNESS:

25 Yrs. old Male patient was apparently normal 9 months back. He was working as driver and stayed with his wife and parents. 9 months back he started developing sleep disturbances. His wife noticed that he woke up mid night and goes nearer to the window and watching outside. She enquired about that. He did not replied for that. Following that his wife noticed that he was withdrawn and not communicating with family members. He started avoiding to going outside. When family members enquired, he replied that people are try to harm him and planed for that. He told that people are watching him and if he goes out of home, they will try to kill him. He slowly stopped going for work. At day time he simply sits inside the home without talking with any one. At night times he kept his bed nearer to the door and frequently gets up and check the door and windows whether they were locked are not. His wife asked about that he told that people are standing outside and tries to harm him. Wife verified and seen no body was there. But he was not convinced. He looks fearful at night time and avoids going outside even for urination.

Wife noticed that he started to talking to himself and at times laughing also. Wife asked about it. He replied that hearing voices of unknown persons, says that they are tries to kill him. At times he closes his ears. Whenever he walks in the street he told that people are talking about him. He started to expresses aggressive and assaultive towards

others. He sits in front of the home and scolded the people who are all crossing his home.

He stopped going to work and stayed inside the home in day time also. He locked the door inside and sits in the bed and always talking to himself. His food intake was decreased and his wife persuaded him to take food. He started suspicious that his wife will mix poison with food to kill him. He slowly avoids taking food given by his wife. His personal care also very deteriorated and he brushes teeth and takes bath once in a week after his wife's compulsion. Due to worsening of his personal care, his family members brought him for magicoreligious treatment. But he was not improved. Then his wife brought him to Govt. Rajaji Hopital, Madurai.

No history of head injury/fever.

No history of seizures.

No history of frequently taking bath.

No history of excessive spending

No history of suicidal wishes.

PAST HISTORY:

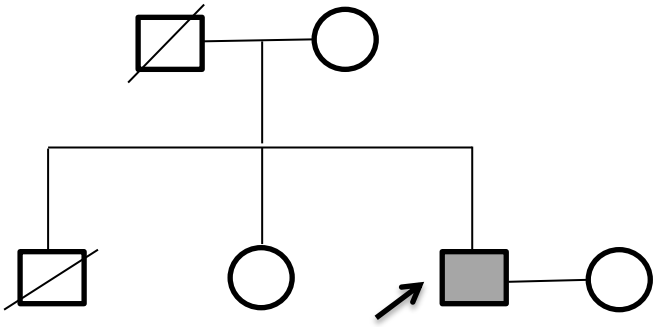
No history of Mental illness.

No history of Hypertension/diabetes mellitus.

No history of Suicide attempt.

No history of head injury/loss of consciousness.

FAMILY HISTORY:



Parents:

Father: Mr.Kulandaivelu, known case of psychiatric illness, ? Schizopherenia , he was withdrawn suspecting his wife muttering to self, poor personal care and wandering tendency. This illness started around the age of 45 yrs. He was treated with magicoreligious treatment for this illness. He died at the age of 55 yrs.

Mother: Mrs. Pechiammal 54 yrs., housewife most affectionate towards his youngest son (pt), advise others and friendly to relatives, kind, affectionate, Dominate the family.

Sibilings:

Mr. Veera Pandi, married, first elder brother of our patient, with history of psychiatric illness, detail, not known and died of Suicide.

Mrs.Alli , Married 32 yrs old, elder sister of our patient, studied upto eighth standard ,healthy, house wife having to children.

Our patient Mr. Subramani is the the third child of his parents, he is from low socio-economical family, from rural back ground.

Mrs. Malliga, 22 yrs old, married to our patient 1½ years back, studied upto tenth standard, healthy and house wife.

PERSONAL HISTORY:

Birth and development :

Full term normal delivery, delivered at home. Cried immediately after birth. No history of Neonatal Jaundice/Seizures. His developmental milestones were normal.

Childhood period :

Patient was healthy during his childhood period. He entered his schoolings at the age of 5 years, attend school regularly, average intelligence, no history of school truancy, passed each class, he will not be helped by parents. He took active part in extra-curricular activities like drama and sports.

Occupational history :

He has changed his job for nearly 6 times due to want of more money. Prior to marriage he worked as Cleaner/conductor/Car/Lorry driver

in which he continued for two years. During these period he used to drive to nearby states and had many premarital contact.

Marital history:

He got married 1 ½ years back and no issues.

Non consanguineous marriage.

His sexual life satisfied.

Substance use history :

Patient is a known smoker for the past five years – 3 cigarettes per day. History of alcohol intake for the past 2 years , once in three months.

No history of cannabis addiction.

Patient involved in politics was interested in campaigning in DMK party and used to express that he will give his life for its leader and his son.

PRE-MORBID PERSONALITY:

He is obedient to his parents.

He is very short tempered and sensitive to criticism

He is very sincere in his work.

Kind and affectionate towards mother and wife

Lack of trust on things basically unless proved or closely moved.

Adjustable, has many friends, active participant was a worker in politics, prefers to talk with others than keeping himself inside, wins in such conversation in favour of his speech not involving in quarrels, showing his main interest in religion, cinema and politics – Extrovert.

General Examination:

Physical Examination:

Pulse rate - 78 / min, regular.

B.P. - 110/70 mm/Hg

Not anaemic / Not Jaundiced & No clubbing /No Pedal edema

Systemic Examination:

Cardio Vascular System	:	S_1, S_2 heard, No murmur
Respiratory system	:	Normal vesicular breath sounds heard
Central Nervous system	:	No focal neurological deficit
Abdomen	:	Soft, no organomegaly
Fundus examination	:	Normal
Thyroid	:	Normal

MENTAL STATUS EXAMINATION:

Patient is conscious, in touch with surroundings

Dressed adequately and un tidy.

Hair not combed.

Gaze contact inadequate,

Rapport could be established with difficulty, cooperative

No tics/mannerisms noticed.

Psychomotor activity: Normal

Attention – Arousable and sustained

Concentration – adequate for the interview

Orientation: Time – able to tell time of day

Place - tell the place

Person- identifies his relatives

Memory: Immediate – DF4 DB3

Recent - able to tell what he ate yesterday night.

Remote - birth place and previous address.

Immediate, recent and remote memories are Normal.

Talk Relevant, coherent, Reaction time prolonged.

Quantum / tone / rate decreased

In between the talk he told he could hear voices but in spite of it he was not disturbed and continued to talk the same.

SAMPLE OF TALK:

என்னை யாரோ ஃபாலோ பன்றாங்க. என்னை கொல்லப்பாக்கறாங்க. நைட் வீட்டுக்கிட்ட நிக்கறாங்க. என்னைய அடிக்க வெயிட் பன்றாங்க. அவங்க பேசறது எனக்கு கேக்குது. நாளஞ்சு ஆளுக கூடி பேசறாக. யாருனு தெரியல. ராத்திரி பகலுனு எல்லா நேரமும் கேக்குது. என்னைய கொல்லத் திட்டம் போட்டுக்கிட்டே இருக்காக. வெளிய எட்டிப்பாத்தா யாரையும் காணோம். ரோட்ல நடந்து போனா, எல்லாரும் என்னைய பத்தியே பேசறாங்க. அவங்கள அடிக்கப் போயிட்டேன். எம் பொண்டாட்டிக்கிட்ட சொன்னா, அவ அப்படியெல்லாம் இல்லைங்கிறா, ஆனாலும் பயமா இருக்குது.

Content – Delusion of persecution

Delusion of reference.

Thought – Form and stream - Normal

Perception: Auditory hallucination +

III person auditory hallucination

Multiple, unknown male voices,

Hearing during day and night times

Threatening

Mood:**Subjective** : நல்லாயிருக்கு! இப்படியிருந்தா எப்படி நல்லாயிருக்கும்**?**

Objective : Irritable / incongruent / Inappropriate affect

General information and intelligence: Adequate.

Abstract Thinking: Proverb Test:

Not able to tell the abstract meaning, but able to tell the concrete meaning of the proverb.

Judgment: Social / Personal / Test situation - Impaired

Insight - Absent

PSYCHOMETRY:

Patient was administered.

1. RORSCHACH INK BLOT TEST
2. THEMATIC APPERCEPTION TEST
3. SENTENCE COMPLETION TEST
4. EYESENCK'S PERSONALITY INVENTORY
5. SCALE FOR ASSESSMENT OF NEGATIVE SYMPTOMS (SANS) AND SCALE FOR ASSESSMENT OF POSITIVE SYMPTOMS (SAPS)

RATIONALE: Rorschach's test was admitted to find out the psychodynamics and psychopathology of the individual.

TAT was administered to find out interpersonal and intrapersonal problems.

EPI was found out the personality of the individual.

The SAPS and SANS were administered to assess the severity of positive and negative symptoms.

PSYCHOLOGICAL REPORT:

Patient remained cooperative, and his motivation was adequate. There were no significant changes in behavior during testing.

The Rorschach findings indicate that the productivity is poor and the cerebration is normal. There was blocking of responses, poor form level responses, perseveration, few popular responses. The form level rating shows fluctuation. This indicated that there was intermittent loss in the reality testing.

The TAT and SCT reveal interpersonal problems with family members, lack of basic trust and ambivalency towards mother.

In EPI he was found to be a dysthymic personality with high degree of Neurotism.

SCHEDULE FOR ASSESSMENT FOR POSITIVE SYMPTOMS:

Score = 43

DIAGNOSTIC FORMULATION:

Subramani, 25 Yrs. Married Male patient brought with complaints of sleep disturbances, withdrawn ,suspiciousness, talking to self, laughing to self, hearing voices, abusive and assaultive behaviour, decreased food

intake, poor personal care for the past 9 months, insidious onset, continuous and progressive illness, first psychiatric consultation with family history of psychiatric illness in father and brother with history of completed suicide of brother, with history of alcohol intake and smoking, with pre morbid personality of extrovert, with Mental Status Examination reveals, delusion of persecution and delusion of reference with third person auditory hallucinations with irritable incongruent mood with inappropriate affect with impaired judgement and abstract thinking with absent insight with no features of organicity offers a diagnosis of Paranoid Schizophrenia. The psychological report also suggestive of this diagnosis.

IMPRESSION: PARANOID SCHIZOPHRENIA - ICD 10 – F.20.0

Management :

Patient was treated as inpatient at Government Rajaji Hospital, Madurai. Investigation's done. Blood TC, DC, ESR, HB, liver function test and Renal function test were within normal limits. He was treated with Tab. Risperidone 2 mg BD, Tab. Diazepam 5 mg one HS and Tab. B complex BD. He was discharged after 25 days. At the time of discharge his score in schedule for assessment for positive symptoms was 24. He was advised to continue the same line of treatment and advised to attend psychiatry out-patient department once in 14 days for regular follow up.

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